Strategic Outlook

Health Care Resource Environment

PMO-529

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Objectives

- Discuss health care cost drivers and their implications for managers and policy makers
- Understand how third party payers reimburse hospitals, physicians and other providers
- Describe financial impact of differing reimbursement systems on providers or a health system

Drivers …… Healthcare Costs

- Legislation
  - BBA – 1997 and BBRA – 1999
  - BIPA (Benefits Improvement and Protection Act) – SCHIP
  - Various Medicare Reimbursement changes
  - Patient Rights Legislation ? (liability cost)
- Uninsured Population
  - Chronic conditions
- Aging Population
- Pharmacy/Technology Advances
  - Blockbuster drugs
  - Medicare prescription benefit
- Less restrictive forms of managed care

CEO Top Issues

- Decrease Costs
- Labor Force Issues
- Consolidate
- Information Technology
- Expand Networks
- Physician Integration

Reimbursement Methods
Overview…

- Discounted FFS
  - Percentage discount from billed charges
- Cost-based reimbursement
  - Cost of care for payer's beneficiaries
- Prospective Payment System (PPS)
  - Fixed fee (in advance) for defined episode of treatment based upon diagnosis

Reimbursement Methods
Overview…

- Resource-based relative value system (RBRVS)
  - Pays on basis of fees derived from relative resource utilization and cost
- Capitation
- Packaged/Bundled Services

Reimbursement Methods
Affect…..

- Hospitals
- Other facilities
  - Rehab, long-term care, etc.
- Physician practices
- Health care goods and services
  - Pharmacy
  - Home health
  - Durable medical equipment

Reimbursement Methods

Incentives…

Reimbursement	Admissions	LOS	Ancillary use
Indemnity, fee For service	↑	↑	↑
Per diem	↑	↑	↓
Global, per case	↑	↓	↓
Capitation	↓	↓	↓

Sources of Health Care Revenue

- Governmental Sources include Medicare, Medicaid, and others
- Managed Care Sources distinguished by types of plans and contracts
- Other Sources include commercial insurers, private pay, and others

Sources of Health Care Revenue

- Sources are generally called “payers”
- “Payer mix” is a measure often included in an organization’s profile
  - Proportion of actual revenues received from different payers
- Management reporting influenced by payer (the revenue source)

Implications of Payer Mix

- Receivables vs. Revenues
  - Charges ≠ reimbursements
  - Receivables estimated based upon services rendered
  - Actual reimbursements (revenues) will vary due to
    - discount arrangements, bad debts, doubtful accounts, charity care

Implications of Payer Mix, cont.

- Pricing
- Internal management of financial and clinical resources
  - Multiple coexisting payment systems (e.g., FFS and capitation) create conflicting pressures
- Incentives – with more payers paying full charges, greater incentive to:
  - Increase volume
  - Increase prices of services with greatest demand
  - Cross subsidize charity care

Deductions from Revenue

Contractual Allowances

- Difference between the full established rate and the agreed-upon contractual rate to be paid

- Different plans commonly pay different contractual rates for the same service

Cost-based Reimbursement

- Reimbursement on the basis of “allowable costs” rather than billed charges
  - Generally allow for some portion of indirect costs (overhead expenses)
  - Disallow charity, education, etc.
- Retrospective
  - Fiscal intermediaries review cost reports
- Settings
  - Psychiatric hospitals, rehab centers, long-term care facilities

Prospective Payment System
DRGs

- Using 23 MDCs, 467 groups formed (later 490+)
- Account for principal diagnosis, patient's age, medical or surgical admission, co-morbidities and complications
- Relative resource cost weights for each DRG
- Case Mix Index
- Medicare adjustments for large, urban facilities, wage index, capital, education, outliers and disproportionate share

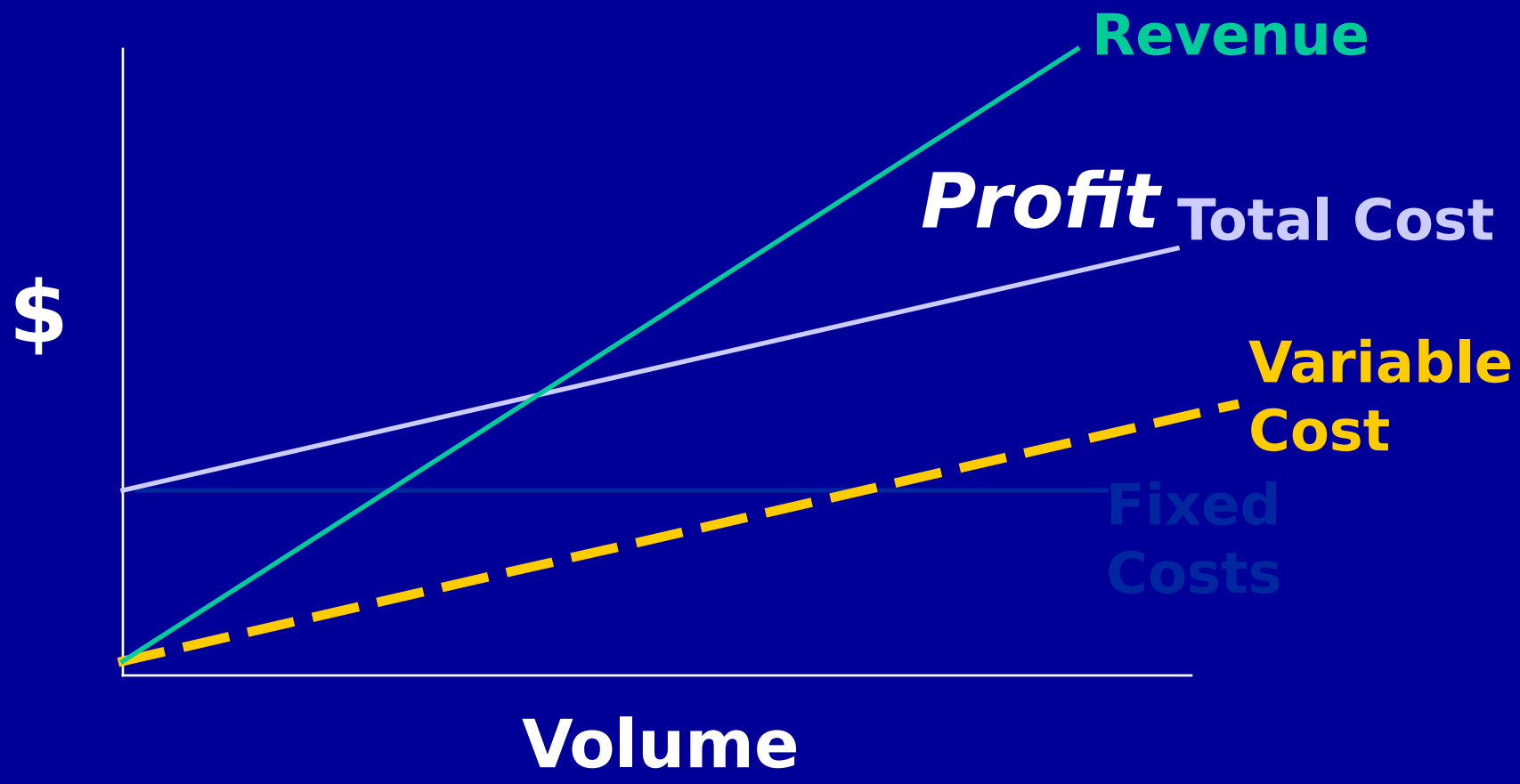
Prospective Payment System -*RBRVS*

- Medicare rates for 7,000 CPT codes (HCFA's common procedure coding system – HCPCS)
- Different schedules for participating and non-participating providers
- Vary regionally (200 locations) – geographic cost indices
- 3 RVUs
  - Work – time, skill levels, stress
  - Practice Expense – non physician costs
  - Malpractice
- Ambulatory patient groupings (8) for care delivered in ambulatory setting

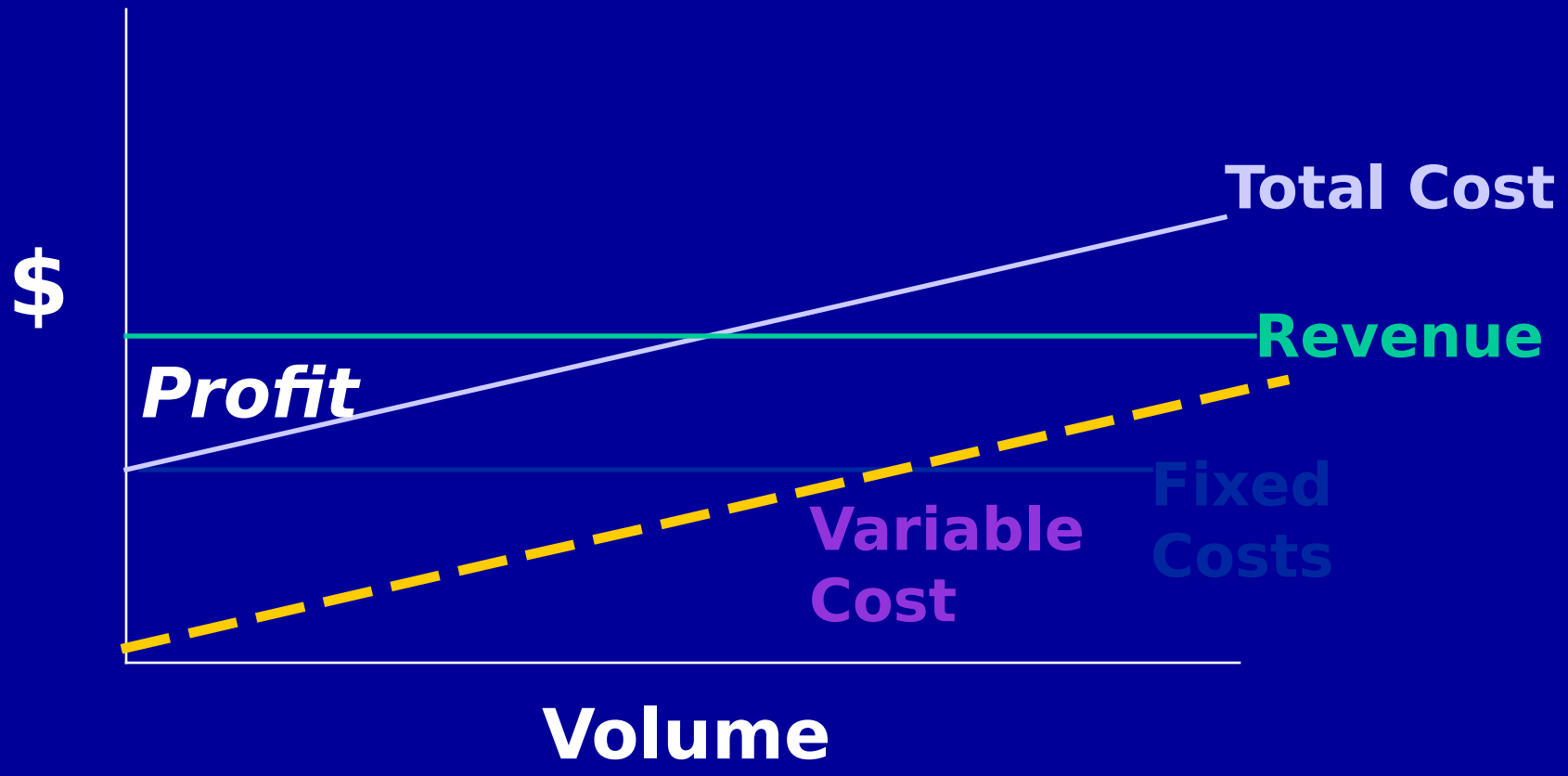
Capitation

- Rationale:
  - Control health care costs
  - Optimize use of health care resources
- Resources based upon:
  - Defined patient population
  - Specific range and intensity of health care services
  - Utilization trends

Cost-based Reimbursement



Source of Profitability Capitation



Economic Risks in Capitation

- Price risk
- Utilization (volume) risk
- Health status risk of the population

- Reimbursement continuum…

  Withholds/Risk pools Global Capitation

  (full “professional risk” capitation)

Why Would Health Plans Use Capitation?

- Shift financial risk to providers
- “Align” financial incentives of the MCO and providers
- Reduces need for utilization review “police”
- Improve budgeting, predictability, and stability of profit margins
- Less costly to administer

Why Would Providers Accept Capitation?

- Protect/increase patient volume
- Predictable, timely cash flow
- Shift focus to prevention/wellness
- Reduce paperwork, less costly to administer
- Lessen micro-management by MCO
- Potential to benefit from cost-effective practice (capture savings)
- Increased ability to monitor patients and (influence) plan services

Risk in Health Plans

- Withholds
  - Percentage of the capitation withheld to provide a pool of money that can be used if medical service costs exceed the MCO's budget
  - If the group meets its economic and utilization objectives, withheld funds are distributed
  - If not – funds are retained by the MCO
- Risk Pools
  - Mechanism to administer withholds
  - Other providers affect the outcome of all participants
- Stop Loss insurance
- Adverse selection
- Leakage
  - Individuals switch out of a plan that offered health promotion services

Pre-Paid Models

- Payer-integrator model
  - Payer manages claims, utilization review
  - Contracts individually with physicians on a capitated basis
  - Hospitals reimbursed on per diem basis
- Payer-contractor
  - Payor contracts with one entity for physician services (e.G.., Ipa) on capitated basis
  - Contracts individually with hospitals on a per diem basis
- Global capitation model
  - Payer contracts with one entity (e.g., PHO) for all healthcare services
  - More control over network and utilization mgmt
- Employer model
  - Provider network (e.g., PHO) contracts directly on an at-risk basis with large employers

Forms of PCP Reimbursement

- Consolidation of health plans has led to broader geographic coverage
- Multiple products offered by the same MCO/plan (FFS, POS, Capitated)
- Self funded/smaller employer plans preferring FFS utilization data
- Carve outs for certain services (specialists, procedures, types of care)

Specialist Reimbursement

- FFS
  - UCR (Usual, Customary and Reasonable)
    - MDR™ database – by region, also provides statistical information
    - Prevailing Healthcare Charges System (old HIAA) database
  - Discounts, Negotiated Fee Schedules, Fee Maximums
  - RBRVS (Fee Allowance)
  - Performance-based FFS (withholds)
- Capitation
  - With and without carve outs
  - Contact Capitation
  - Participation in (referral) risk pools
- Salaried

Questions?